

**THE BELOW INFORMATION IS TO BE FILLED OUT ON THE PERSON
RESPONSIBLE FOR ANY CHARGES**

**IF YOU ARE BEING SEEN TODAY FOR A SERVICE THAT YOU DO NOT
WISH TO LIST A PARENT'S NAME AND YOU ARE A MINOR YOU MAY
FILL IN YOUR INFORMATION BELOW SO YOUR PARENT DOES NOT
RECEIVE A BILL**

LAST NAME:_____

FIRST NAME:_____

MIDDLE INITIAL:_____

SUFFIX:_____ (Jr., Sr, 1st, 2nd etc)

SS#:_____ **REQUIRED FOR HEAD OF HOUSEHOLD**

RELATIONSHIP TO FAMILY: HEAD OF HOUSEHOLD

BIRTH DATE:_____

SEX:_____

PRIMARY RACE:_____

ARE YOU HISPANIC OR LATINO? _____

ETHNIC ORIGIN:_____ **(COUNTRY IN
WHICH YOU WERE BORN)**

BILLING ADDRESS:

HOUSE#:_____

PRE-DIRECTION OF ADDRESS:_____ (NORTH, SOUTH, EAST, WEST)

NAME OF STREET:_____

STREET SUFFIX:_____ (AVE, ST, RD ETC)

POST DIRECTION:_____ (NE, SW ETC)

APT #:_____

ZIP CODE:_____

CITY:_____

STATE:_____

HOME ADDRESS:

HOUSE#:_____

PRE-DIRECTION OF ADDRESS:_____ (NORTH, SOUTH, EAST, WEST)

NAME OF STREET:_____

STREET SUFFIX:_____ (AVE, ST, RD ETC)

POST DIRECTION:_____ (NE, SW ETC)

APT #:_____

ZIP CODE:_____

CITY:_____

STATE:_____

TELEPHONE NUMBERS:

**DO NOT LIST A NUMBER BELOW THAT YOU WOULD NOT
WANT US TO CALL**

HOME: _____

CELL: _____

SCHOOL: _____

WORK: _____

EMERGENCY CONTACT:

RELATIONSHIP TO YOU: _____

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

HOME PHONE NUMBER FOR EMERGENCY CONTACT:

_____-_____-_____ **INCLUDE AREA CODE**

WORK PHONE NUMBER FOR EMERGENCY CONTACT

_____-_____-_____ **INCLUDE AREA CODE**

_____ **INCLUDE EXTENSION**

LIST BELOW PERSON (s) TO BE SEEN TODAY:

SS#_____

LAST NAME:_____

FIRST NAME:_____

MIDDLE INITIAL:_____

**RELATIONSHIP TO PERSON LISTED AS RESPONSIBLE FOR CHARGES ON
1ST PAGE:**_____

BIRTH DATE:_____

SEX:_____

PRIMARY RACE:_____

VOTING STATUS:_____ (REGISTERED, NOT ELIGIBLE
ETC)

MARITAL STATUS:_____ (SINGLE, MARRIED, DIVORCED,
WIDOWED ETC)

IS THIS PERSON HISPANIC OR LATINO?_____

**IF HISPANIC OR LATINO WHICH COUNTRY WERE YOU
BORN?**_____

DOES THIS PERSON HAVE HEALTH INSURANCE?_____

ADDITIONAL INFORMATION:

**DOES THIS PERSON PARTICIPATE IN THE FREE LUNCH PROGRAM AT
SCHOOL:**_____

IF YES, EFFECTIVE WHAT DATE:_____

WHAT SERVICE ARE THEY HERE FOR TODAY? _____

Please list all immediate family members below. If more than the person above is to be seen today please indicate below.

TO BE SEEN TODAY? YES___NO___

FOR WHAT SERVICE?_____

SS#_____

LAST NAME:_____

FIRST NAME:_____

MIDDLE INITIAL:_____

RELATIONSHIP TO PERSON LISTED AS RESPONSIBLE FOR CHARGES ON 1ST PAGE:_____

BIRTH DATE:_____

SEX:_____

PRIMARY RACE:_____

VOTING STATUS:_____ (REGISTERED, NOT ELIGIBLE ETC)

MARITAL STATUS:_____ (SINGLE, MARRIED, DIVORCED, WIDOWED ETC)

IS THIS PERSON HISPANIC OR LATINO?_____

IF HISPANIC OR LATINO WHICH COUNTRY WERE YOU BORN?_____

DOES THIS PERSON HAVE HEALTH INSURANCE?_____

ADDITIONAL INFORMATION:

DOES THIS PERSON PARTICIPATE IN THE FREE LUNCH PROGRAM AT SCHOOL:_____

IF YES, EFFECTIVE WHAT DATE:_____

TO BE SEEN TODAY? YES_____NO_____

FOR WHAT SERVICE?_____

SS#_____

LAST NAME:_____

FIRST NAME:_____

MIDDLE INITIAL:_____

**RELATIONSHIP TO PERSON LISTED AS RESPONSIBLE FOR CHARGES ON
1ST PAGE:_____**

BIRTH DATE:_____

SEX:_____

PRIMARY RACE:_____

**VOTING STATUS:_____ (REGISTERED, NOT ELIGIBLE
ETC)**

**MARITAL STATUS:_____ (SINGLE, MARRIED, DIVORCED,
WIDOWED ETC)**

IS THIS PERSON HISPANIC OR LATINO?_____

**IF HISPANIC OR LATINO WHICH COUNTRY WERE YOU
BORN?_____**

DOES THIS PERSON HAVE HEALTH INSURANCE?_____

ADDITIONAL INFORMATION:

**DOES THIS PERSON PARTICIPATE IN THE FREE LUNCH PROGRAM AT
SCHOOL:_____**

IF YES, EFFECTIVE WHAT DATE:_____

TO BE SEEN TODAY? YES_____NO_____

FOR WHAT SERVICE?_____

SS#_____

LAST NAME:_____

FIRST NAME:_____

MIDDLE INITIAL:_____

**RELATIONSHIP TO PERSON LISTED AS RESPONSIBLE FOR CHARGES ON
1ST PAGE:_____**

BIRTH DATE:_____

SEX:_____

PRIMARY RACE:_____

**VOTING STATUS:_____ (REGISTERED, NOT ELIGIBLE
ETC)**

**MARITAL STATUS:_____ (SINGLE, MARRIED, DIVORCED,
WIDOWED ETC)**

IS THIS PERSON HISPANIC OR LATINO?_____

**IF HISPANIC OR LATINO WHICH COUNTRY WERE YOU
BORN?_____**

DOES THIS PERSON HAVE HEALTH INSURANCE?_____

ADDITIONAL INFORMATION:

**DOES THIS PERSON PARTICIPATE IN THE FREE LUNCH PROGRAM AT
SCHOOL:_____**

IF YES, EFFECTIVE WHAT DATE:_____

Does anyone in the family have Medicaid? Yes ___No___
IF YES WHO?_____

Does anyone in the family have Unicare? Yes ___No___
IF YES WHO?_____

Does anyone in the family have Famis/Medallion? Yes ___No___
IF YES WHO?_____

Does anyone in the family have Medicare? Yes ___No___
IF YES WHO?_____

Does anyone in the family have Health Insurance? Yes ___No___
IF YES WHO?_____

You are required to show their card for eligibility purposes each time they visit clinic.

IF YOU ARE COMPLETING ELIGIBILITY TODAY – HOW MANY PEOPLE DOES THE PROOF OF INCOME YOU BROUGHT IN TODAY SUPPORT? Please list their names and relationship to the person applying for services below: